Integrative Developmental and Behavioral Pediatrics, LLC

PATIENT REGISTRATION

Patient Name____DOB________________Gender (M/F/other)

Parent/Guardian #1____DOB____________Gender (M/F/other)

Relationship to patient____

Address____Home phone___________________________

City/State/Zip____Cell Phone_____________________________

Employer/Occupation____Work phone____________________________

Communication by email represents a potential risk to patient confidentiality. By furnishing my email, I consent to the use of email to communicate. Email:____

Would you like to receive information by email about changes to our office schedule or location, community resources and general medical information from our practice? (1-4 emails per month). **Please circle one: yes / no / will decide later**

We sometimes host medical students or physicians who appreciate observing appointments to learn more about developmental and behavioral pediatrics. Would you feel comfortable with an observer during your appointment? You can always change your mind, even at the last minute. **Please circle one: yes / no / will decide later / please ask before each appointment**

Please indicate best way to contact you: **Please circle one: cell / home / email / other:_____________________________________**

Parent/Guardian #2____DOB____________Gender (M/F/other)

Relationship to patient____

Address____Home phone___________________________

City/State/Zip____Cell Phone_____________________________

Employer/Occupation____Work phone____________________________

Communication by email represents a potential risk to patient confidentiality. By furnishing my email, I consent to the use of email to communicate. Email:____

Would you like to receive information about changes to our office schedule or location, community resources and general medical information from our practice via email? (1-4 emails per month). **Please circle one: yes / no / will decide later**

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Please indicate best way to contact you: **Please circle one: cell / home / email / other:_____________________________________**

***PLEASE COMPLETE "ADDITIONAL PARENTS / GUARDIANS FORM" IF YOU WOULD LIKE TO LIST MORE THAN TWO PARENTS/GUARDIANS**

PATIENT REGISTRATION, page 2

Parents are: (circle all that apply): Married / Living together / Separated / Divorced / Other

If parents are not married, who is the custodial parent?____

Sibling Name____DOB________________Gender (M/F/other)

Sibling Name____DOB________________Gender (M/F/other)

Sibling Name____DOB________________Gender (M/F/other)

Sibling Name____DOB________________Gender (M/F/other)

Additional siblings____

Emergency Contact Person____

Emergency Contact primary phone #______________________________secondary phone #________________________________

Who may we thank for referring you to us?____

Patient Signature (if 14 or older)____Date________________

Parent/Guardian Signature____Date________________

Printed name of Parent/Guardian____